STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 01 B. WING _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/27/11 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Lutheran Life Villages was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility with a basement was determined to be of Type I (332) construction and partially sprinklered (The Phrenic wing, Peerage wing and the number ten dining room were sprinklered). The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and all resident rooms in the main building. Single station battery operated smoke detector are installed in all resident rooms in the Health and Rehabilitation Center. The facility has a capacity of 262 and had a census of 127 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on	K 000	See ATTACHED RECEIVED FEB 22 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

APPROVED
3/1/11 DA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

HFA — HFA — 2/16/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 02/02/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 Social Service office corridor doors and 1 of 1 oxygen storage room corridor doors were constructed to resist the passage of smoke. This deficient practice could affect all residents in or near the Social Service and in the Administration corridor of the Health Care building.	K 018		

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K 018	Continued From page 2 Findings include: Based on observations with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 from 12:47 p.m. to 1:22 p.m., the corridor door to the Social Service office had a sixteen by sixteen inch vent in the door. The oxygen storage room has a twenty four by twenty four inch vent in the door that was equipped with a fusible link but did not resist the passage of smoke. Measurements were provided by the Maintenance Director. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 14 resident room doors on B wing protecting corridor openings. This deficient practice could affect all 22 residents on B wing. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/10 at 1:19 p.m., the corridor door to resident room 209B could not be closed due to a night stand with a TV sitting on top of it. This was acknowledged by the Assistant Maintenance Director. 3.1-19(b)	K 018		
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3	K 039		

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K 039	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 Peerage exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect any residents evacuated through Peerage wing exit # 75 in the event of an emergency. Findings include: Based on an observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 2:02 p.m., Peerage wing exit # 75 was obstructed by a clean linen cart and a beverage cart stored in the exit discharge path which decreased the exit width to thirty six inches. This was acknowledged by the Maintenance Director and the Assistant Maintenance Director at the time of observation 3.1-19(b)	K 039		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 emergency lights were tested annually for at least a 1½ hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on	K 046		

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K 046	Continued From page 4 every required battery powered emergency lighting system annually for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Director and Assistant Maintenance Director on 01/27/11 from 11:35 a.m. to 12:00 p.m., a battery operated emergency light was observed at the generator for the main building and at the generator for the Health Care building. Based on an interview with the Maintenance Director and the Assistant Maintenance Director at 11:35 a.m., there was no written record of an annual test for the battery operated emergency lights available for review. 3.1-19(b)	K 046		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		

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K 050	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for the third shift for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Alarm Report" forms with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 10:15 a.m., all third shift fire drills took place between 5:30 a.m. and 6:15 a.m. for four of the last four quarters. This was acknowledged by the Maintenance Director at the time of record review. 3.1-19(b) 3.1-51(c)	K 050		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers near exit 75 was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect all 28 residents on Peerage wing evacuated through exit # 75 in the	K 064		

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K 064	Continued From page 6 event of an emergency. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 2:03 p.m., access to the exit # 75 fire extinguisher was obstructed by a beverage cart. This was acknowledged by the Maintenance Director and Assistant Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Health Care kitchen portable fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice could affect any number of kitchen staff in the event of an emergency. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 1:29 p.m., the Health Care kitchen fire extinguisher was mounted on wall seventy inches from the floor to the top of the fire extinguisher. Measurements were provided by Maintenance Director.	K 064		
K 144 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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K 144	Continued From page 7 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 2 of 2 emergency generators were equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 during a tour of the facility from 11:00 a.m. to 3:30 p.m., the facility did not have a	K 144		

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K 144	Continued From page 8 remote manual stop for either of the emergency generators. Based on an interview with the Maintenance Director and the Assistant Maintenance Director at 10:35 a.m., the generator powering the main building had a 156 horsepower motor and the generator powering the Health Care building had a 153 horsepower motor. 3-1.19(b) 2. Based on interview and record review, the facility failed to ensure the off site fuel source for 2 of 2 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquifed petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the	K 144		

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K 144	Continued From page 9 natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 10:23 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated March 9, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas and low probability of interruption of the natural gas service. This was acknowledged by the Maintenance Director and the Assistant Maintenance Director during the time of record review.	K 144		
K 147 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 wet location resident care areas such as the basement Beauty shop was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all residents in the basement Beauty shop in the event of an emergency. Findings include: Based on an observation with the Maintenance Director and the Assistant Maintenance Director on 01/27/11 at 11:20 a.m., the basement Beauty shop had an electrical receptacle on the wall within three feet of a sink that was not provided with GFCI protection to prevent electric shock. Additionally, the following staff areas had an electrical receptacles on the wall within three feet of a sink that were not provided with GFCI protection: the clean and soiled utility rooms on A, B and D wings. Based on an interview with the Assistant Maintenance Director at the time of observations, he confirmed the circuit breaker for these outlets were not provided with GFCI protection to prevent electric shock. 3.1-19(b)	K 147		

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Lutheran Life Villages
6701 S. Anthony Blvd.
Fort Wayne, IN 46816
260.447.0800

Preparation and execution of this response and plan of correction do not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Lutheran Home's allegation of compliance.

Plan of Correction

K 018 - NFPA 101: Doors Protecting Corridor Openings

1. What measures were taken for residents directly affected?

No specific residents were affected by this deficient practice.

2. What measures were put in place to identify other residents at risk?

All residents have the potential to be affected by this deficient practice.

3. What systemic change was put in place to ensure the deficient practice does not recur?

1) All doors protecting corridor openings will be inspected for resistance to smoke passage. Doors not meeting requirement will be repaired or replaced. Any new doors needed in corridor openings will specified to meet NFPA 101 requirements and verified upon delivery.

2) Director or Assistant Director of Maintenance will inspect resident rooms weekly for twelve weeks and remove any obstructions to corridor doors or report any obstructions to maintenance for further corrective action.

4. How will the corrective action be monitored?

1) Any projects that require a new door or moving of an existing door will be reviewed by the Director or Assistant Director of Maintenance for compliance.

5. By what date will these changes be completed?

February 26, 2011

Plan of Correction

K 039 - NFPA 101: Width of Aisles or Corridors Serving as Exits

1. **What measures were taken for residents directly affected?**

No specific residents were affected by this deficient practice.

2. **What measures were put in place to identify other residents at risk?**

All residents have the potential to be affected by this deficient practice.

3. **What systemic change was put in place to ensure the deficient practice does not recur?**

Housekeeping, Nursing and Dining Services staff have been instructed to not leave carts in exit paths and to move any carts they observe in exits paths to a safe location. This requirement is being covered in employee in-service training for all staff working in the resident areas.

4. **How will the corrective action be monitored?**

Director or Assistant Director of Maintenance will monitor the clearance in exits weekly for twelve weeks. Maintenance monitors exits clearance in any area they are performing work in.

5. **By what date will these changes be completed?**

February 26, 2011

Plan of Correction

K 046 - NFPA 101: Emergency Lighting Of At least 1 ½ hours Duration

1. **What measures were taken for residents directly affected?**

No specific residents were affected by this deficient practice.

2. **What measures were put in place to identify other residents at risk?**

All residents have the potential to be affected by this deficient practice.

3. **What systemic change was put in place to ensure the deficient practice does not recur?**

The annual 1 ½ hour duration test has been added to the preventive maintenance schedule and in the future, will be completed every January.

4. **How will the corrective action be monitored?**

This test is monitored by the Assistant Director of Maintenance by reviewing the January preventive maintenance task list upon completion.

5. **By what date will these changes be completed?**

February 26, 2011

Plan of Correction

K 050 - NFPA 101: Fire Drills Held At Unexpected Times Under Varying Conditions.

1. **What measures were taken for residents directly affected?**

No specific residents were affected by this deficient practice.

2. **What measures were put in place to identify other residents at risk?**

All residents have the potential to be affected by this deficient practice.

3. **What systemic change was put in place to ensure the deficient practice does not recur?**

The Assistant Director of Maintenance/Safety Director has scheduled 3rd shift fire drills for varied times between 9pm and 6am. These drills are being coordinated with the 3rd shift charge nurse for compliance.

4. **How will the corrective action be monitored?**

These drills are conducted or monitored by the Assistant Director of Maintenance/Safety Director. Times of drills are reviewed by the Director of Maintenance monthly.

5. **By what date will these changes be completed?**

February 26, 2011

Plan of Correction

K 064 - NFPA 101: Portable Fire Extinguishers Are Provided And Readily Accessible.

1. What measures were taken for residents directly affected?

No specific residents were affected by this deficient practice.

2. What measures were put in place to identify other residents at risk?

All residents have the potential to be affected by this deficient practice.

3. What systemic change was put in place to ensure the deficient practice does not recur?

1) Maintenance, Housekeeping, Nursing and Dining Services staff have been instructed to not to obstruct access to fire extinguishers and to move any carts or other obstructions they observe that prevents free and clear access to any fire extinguishers. This requirement is being covered in employee in-service training and new hire orientation for all staff working in the resident areas.

2) All new wall mount installations will be no higher than 60" as required by NFPA 101.

4. How will the corrective action be monitored?

1) Maintenance Department employees will monitor fire extinguisher access on an on-going basis in any areas they are performing work.

2) It has been added to the fire extinguisher annual inspect task list that all wall mounted extinguishers are checked annually for proper height, not to exceed 60"

5. By what date will these changes be completed?

February 26, 2011

Plan of Correction

K 144 - NFPA 101: Generator Weekly Inspections and Monthly Exercise Under Load.

1. What measures were taken for residents directly affected?

No specific residents were affected by this deficient practice.

2. What measures were put in place to identify other residents at risk?

All residents have the potential to be affected by this deficient practice.

3. What systemic change was put in place to ensure the deficient practice does not recur?

1) Bids are being obtained from generator service companies for the installation of remote manual stops located in a room outside the room housing the prime movers. Bid will be let by 2/18/2011 and work will be completed by 2/26/2011.
2) A new letter of reliability of fuel source has been obtained by Assistant Director of Maintenance from our utility provider and no further action should be necessary.

4. How will the corrective action be monitored?

1) Remote manual stop installations will be completed by 2/26/2011 and no further monitoring should be necessary.
2) We have received the updated letter of fuel source reliability from our utility provider. The letter contains the elements required and no further action should be necessary.

5. By what date will these changes be completed?

February 26, 2011

Plan of Correction

K 147 - NFPA 101: Electrical Wiring and Equipment In Accordance With NPFA 70.

1. **What measures were taken for residents directly affected?**

No specific residents were affected by this deficient practice.

2. **What measures were put in place to identify other residents at risk?**

All residents have the potential to be affected by this deficient practice.

3. **What systemic change was put in place to ensure the deficient practice does not recur?**

Non-GFCI electrical receptacles that were with 3 feet of a water source were permanently replaced with GFCI type receptacles in the Assisted Living building basement beauty shop and in the clean and soiled utility rooms on A, B and D wings as required.

The maintenance staff has been in-serviced that any future electrical device installations within 3 feet of a water source will be of a GFCI type in compliance with NFPA 70.

4. **How will the corrective action be monitored?**

These GFCI replacements are considered permanent and have already been completed. They will be inspected by the Director of Maintenance and no further action should be necessary.

5. **By what date will these changes be completed?**

February 26, 2011